

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297034		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2009	
NAME OF PROVIDER OR SUPPLIER HARMONY HOME HEALTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 RANCHO LN #20 LAS VEGAS, NV 89106			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of the Medicare re-certification survey under 42 CFR Part 484 - Home Health Services, conducted at your agency from June 15-18, 2009.</p> <p>The active census on the first day of the survey was 62.</p> <ul style="list-style-type: none"> - 12 clinical records were reviewed. - 5 home visits were conducted. <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The agency failed to maintain condition level compliance with the following Conditions of Participation:</p> <p>42 CFR 484.14 Organization, Services, and Administration 42 CFR 484.20 Reporting OASIS Information</p> <p>The following regulatory deficiencies were identified.</p>			G 000			
G 106	<p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p>			G 106			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 106	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure patients admitted to the agency were informed either verbally or in writing of the grievance policy or procedure for 2 of 12 patients (#5, #1).</p> <p>Findings include:</p> <p>A home visit was conducted on 6/15/09, with Patient #5 and the licensed practical nurse, Employee #3. During the visit, Patient #5 was asked if she was aware of the facility grievance process, or the hot line access number. Patient #5 confirmed she was not aware of either one.</p> <p>The patient handbook information located in Patient #5's home revealed there was no copy of the facility's grievance policy or procedure. A review of the patient information handbook located in the office revealed the consents signed by patients did not include acknowledgement that patients were informed of a grievance policy or procedure.</p> <p>A home visit was conducted on 6/16/09, with Patient #1. He stated that he was told if there was a problem to call the Administrator/ Director of Professional services.</p> <p>Review of documents identified as "Notice of Privacy Practices" revealed on page four, directions of how to file a complaint about privacy practices and included, "The name, address, and telephone number of the person to whom you may file your complaint is listed on the last page of this document." The contact address and phone number of the privacy officer was in Utah. There was no other information regarding how to</p>	G 106			

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G 106	Continued From page 2 report any other grievances, except those dealing with privacy of the patient. An interview with the Administrator/ Director of Professional Services on 6/16/09, revealed there were no grievance policies and procedures. She was also not aware the privacy complaint information had not been updated with a Nevada toll free hot line number.	G 106			
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on interview, the agency failed to maintain a record of all complaints voiced by agency patients and to maintain documentation of the investigative process and the resolution of the complaint. Findings include: An interview was conducted with the agency Administrator/Director of Professional Services (A/DOPS) on 6/16/09. The A/DOPS disclosed that she did not maintain documentation of patient complaints unless the complaint resulted in the employee involved needing counseling regarding the issue. The A/DOPS added that to date she had not needed to take that action.	G 107			

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G 116	<p>484.10(f) HOME HEALTH HOTLINE</p> <p>The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure patients admitted to the agency were informed either verbally or in writing of the toll free hotline number established by the state or its purpose for 2 of 12 patients (#5, #1).</p> <p>Findings include:</p> <p>A home visit was conducted on 6/15/09, with Patient #5 and the licensed practical nurse, Employee #3.</p> <p>During the visit, Patient #5 was asked if she was aware of the facility grievance process, or the hot line access number. Patient #5 confirmed she was not aware of either one. Review of her admission patient handbook revealed there was no toll-free hotline number or address for the Nevada state agency responsible to investigate concerns or complaints.</p>	G 116			

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TU2D11 Facility ID: NVS596HHA If continuation sheet Page 5 of 45

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G 122	Continued From page 5 the patient care level which were clearly set forth in writing and were readily identifiable (G123); failed to ensure the governing body assumed full legal authority and responsibility for the operation of the agency (G128); failed to appoint a qualified administrator (G129); failed to oversee the management and fiscal affairs of the agency (G132); failed to ensure that the administrator organized and directed the agency's ongoing functions; maintained ongoing liaison among the governing body, the group of professional personnel and the staff (G133); failed to ensure the administrator employed qualified personnel and ensured adequate staff education and evaluations (G134); failed to implement an effective budgeting and accounting system (G136); failed to ensure a qualified person was authorized to act in the absence of the administrator (G137); failed to demonstrate that patient care was coordinated effectively to support the plan of care (G 143); failed to ensure the clinical record provided evidence of case conferences that established effective interchange, reporting, and coordination of patient care between disciplines and the physician (G 144); failed to provide a written summary report for each patient to the physician at least every 60 days (G 145); failed to establish an overall plan and budget that included an annual operating budget and capital expenditure plan and an annual review of the overall plan and budget (G148) and (G149).			G 122			
G 123	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily			G 123			

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G 123	Continued From page 6 identifiable. This STANDARD is not met as evidenced by: Based on interview and document review, the agency failed to identify the lines of authority in writing. Findings include: The Administrator/Director of Professional Services (A/DOPS) was interviewed on 6/16/09. She disclosed that in her absence, the Assistant Director of Professional Services was the responsible person in charge of the agency. The A/DOPS was unable to provide proof of that delegation of responsibility in writing.	G 123			
G 128	See Tag G137 484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. This STANDARD is not met as evidenced by: Based on interview, the governing body failed to be responsible for the operation of the agency. Findings included: In an interview with the Administrator/Director of Professional Services on 6/17/09, she stated that she had no contact with the governing body, either in person or in the form of governing body minutes.	G 128			

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G 129	<p>484.14(b) GOVERNING BODY</p> <p>The governing body appoints a qualified administrator.</p> <p>This STANDARD is not met as evidenced by: Based on interview, the agency failed to provide evidence that the administrator had been approved and appointed by the governing body.</p> <p>Findings include:</p> <p>The Administrator/Director of Professional Services was interviewed 6/17/09. During the interview, she revealed there was no written evidence that the governing body had approved the appointment of the Administrator to her present position.</p>	G 129			
G 132	<p>484.14(b) GOVERNING BODY</p> <p>The governing body oversees the management and fiscal affairs of the agency.</p> <p>This STANDARD is not met as evidenced by: Based on interview, the governing body failed to oversee the fiscal affairs of the agency.</p> <p>Findings include:</p> <p>An interview was conducted with the Administrator/Director of Professional Services on 6/17/09. She revealed the governing body was located at the corporate headquarters in another state, and to her knowledge had never convened regarding her agency. She was not able to produce any written documentation to support that the governing body was, in fact, overseeing the the functions of the agency.</p>	G 132			

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G 133	<p>484.14(c) ADMINISTRATOR</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>This STANDARD is not met as evidenced by: Based on interview, the facility administrator failed to serve as a liaison between the agency and the governing body.</p> <p>Findings include:</p> <p>An interview was conducted with the agency's Administrator / Director of Professional Services on 6/17/09. During the interview, she disclosed that she never had any interaction with the governing body of the agency.</p>			G 133			
G 134	<p>484.14(c) ADMINISTRATOR</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p> <p>This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure that agency staff had adequate staff education.</p> <p>Findings include:</p> <p>During an interview with the agency Administrator / Director of Professional Services (A/DOPS) on 6/16/09, she revealed that she did not provide any</p>			G 134			

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G 134	Continued From page 9 on site educational process on a regular basis or did she maintain any record of staff education. The A/DOPS provided information where certain courses were available on line. These classes did not necessarily pertain to specific interests or needs of the agency or their patient population. The A/DOPS did not follow up or require documentation from the staff in regards to completion of the on line courses.	G 134			
G 136	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, implements an effective budgeting and accounting system. This STANDARD is not met as evidenced by: Based on interview, the agency failed to ensure that the administrator was involved in the implementation of the budgeting and accounting system. Findings include: In an interview with the Administrator on 6/17/09, it was disclosed that she was not involved in the budgeting and accounting process and was unaware of what the agency's budget entailed.	G 136			
G 137	484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. This STANDARD is not met as evidenced by: Based on interview, the agency failed to provide authorization in writing, of a qualified person to act in the absence of the administrator.	G 137			

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G 137	Continued From page 10 Findings include: The Administrator/Director of Professional Services (A/DOPS) was interviewed on 6/16/09. She disclosed that in her absence, the Assistant Director of Professional Services was the responsible person in charge of the agency. The A/DOPS was unable to provide proof of that delegation of responsibility in writing.	G 137			
G 143	See Tag G123 484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate that patient care was coordinated effectively to support the plan of care of the patients for 3 of 12 patients (#9, #12, #1). Findings include: Patient #9 Patient #9 was a current patient as of 6/15/09 who was admitted on 3/12/09, with a primary diagnosis of Vitamin B 12 deficiency. The physician prescribed weekly administration of vitamin B 12 injections for four weeks then the injections were scheduled monthly. He resided in an assisted living facility.	G 143			

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G 143	<p>Continued From page 11</p> <p>Review of the clinical record revealed Patient #9 only received three of the four weekly injections (3/12/09, 3/20/09 and 3/27/09). There was no evidence explaining the reason the fourth weekly dose was not administered. There was no evidence the physician was informed.</p> <p>Patient #12</p> <p>Patient #12 was admitted to the agency on 12/6/08, and discharged on 2/3/09. His primary diagnosis was chronic obstructive pulmonary disease.</p> <p>1. Patient #12 was initially prescribed a licensed nurse three times a week and a nurses aide once a week. Patient #12 was transferred back to the hospital nine days later on 12/15/08. A missed nursing aide visit was documented on 12/16/08.</p> <p>An interview with the Administrator/Director of Patient Services (A/DOPS) on 6/17/09 revealed the nursing aide was not informed of Patient #12's transfer to the hospital.</p> <p>2. Patient #12's initial referral from the VA (Veteran's Administration) contained a physician's order for occupational therapy. The typed plan of care for 12/6/08-2/3/09, included a hand written order by the physician specifically requesting occupational therapy evaluation and treatment. There was no evidence that occupational therapy was informed of these orders.</p> <p>An interview with the A/DOPS on 6/17/09, revealed that occupational therapy had not been instructed to evaluate this patient.</p> <p>Patient #1</p>	G 143			

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G 143	Continued From page 12 Patient #1 recently required amputation of his left lower extremity, below the knee. He was dependent upon his wife for assistance with most activities of daily living, however his wife was disabled. Patient #1 required more assistance financially as well as physically for his ongoing health. Patient #1 received hemodialysis three times a week. An interview with the Administrator / Director of Professional Services on 6/17/09, revealed she was not aware that dialysis patients had assigned social workers who assisted patients in finding social programs to meet their needs.	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the clinical record provided evidence of case conferences that established effective interchange, reporting, and coordination of patient care between disciplines and the physician in 11 of 12 records reviewed. Findings include: An interview with the Administrator/ Director of Patient Services (A/DOPS) on 6/17/09, confirmed that staff may communicate with the physician	G 144			

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G 144	Continued From page 13 and/or other staff members but they did not document these conferences. There was no structured case conference meetings by agency staff. Examples of lack of reporting or coordination of patient care were the following: 1. An interview with a registered nurse, Employee #2 on 6/17/09 at 10:00 AM, revealed she did not perform any structured review of the licensed practical nurses and certified nurses aides regarding the written plan of care compliance with the patients or the staff, she as case manager was responsible for. 2. Home visit review of four of five patients (#1, #3, #5, #6) and one clinical record (Patient #9) revealed discrepancies in the medication profile which included these patients taking medications differently than prescribed. Patient #3 had duplicated medications. There was evidence these patients were taking medications other than were ordered. There was no evidence the physicians were informed of the discrepancies in administration or duplication with the medications. 3. Patient #12 was prescribed physical therapy twice a week but was seen three days in one week and twice on one of those days. There was no evidence of communication between physical therapy staff.	G 144			
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.	G 145			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2009
NAME OF PROVIDER OR SUPPLIER HARMONY HOME HEALTH, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 820 RANCHO LN #20 LAS VEGAS, NV 89106		
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G 145	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to provide a written summary report for each patient to the physician at least every 60 days for one of one patient who was on service longer than one certification period (#9).</p> <p>Findings include:</p> <p>A summary report, by definition, was to be a compilation of the pertinent factors of a patient's clinical notes and progress notes that were submitted to the patient's physician.</p> <p>Patient #9</p> <p>Patient #9 was admitted to the agency on 3/13/09 and was recertified on 5/12/09. His primary diagnosis was a vitamin B 12 deficiency anemia. He resided in an assisted living facility. Patient #9 was to receive B 12 injections weekly for four weeks and then the B 12 injections were to be administered monthly. Review of the clinical record revealed Patient #9 received only three weekly injections.</p> <p>The 60 day summary was part of the recertification plan of care. The 60 day summary was the following: "Patient has tolerated B 12 injections without adverse reactions." There was no compilation of the pertinent factors such as: -available caregiver to be instructed on administration of the B 12 injections, the missed dose, Patient #9's vital signs, or any specific teaching and its effectiveness.</p> <p>Interview with the Administrator/Director of Patient Services on 6/17/09, confirmed she wrote the clinical summary but did not know what was</p>	G 145			

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G 145	Continued From page 15 needed to be included.	G 145			
G 148	484.14(i) INSTITUTIONAL PLANNING The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA. This STANDARD is not met as evidenced by: Based on interview, the governing body failed to develop an overall plan and budget under the direction of a committee that included representation from the governing body, the administrative staff and the medical staff. Findings include: In an interview conducted with the Administrator on 6/17/09, she disclosed that she had no participation in the development of the overall plan and budget for the agency.	G 148			
G 149	484.14(i) INSTITUTIONAL PLANNING The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA. This STANDARD is not met as evidenced by: Based on interview, the agency failed to ensure that the overall plan and budget were reviewed and revised on an at least annual basis by a committee comprised of a representative from the	G 149			

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G 149	Continued From page 16 governing body, the agency's medical staff, and the agency's administrative staff. Findings include: During an interview with the agency's administrator on 6/17/09, she revealed that she was not aware of the contents of the budget nor did she have any involvement with the development of the budget.	G 149			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure staff administered care in accordance with the plan of care established by the physician for 6 of 12 patients (#4, #6, #9, #12, #1, #10). Findings include: Patient #4 Patient #4 was admitted to the agency on Tuesday, 4/28/09, with diagnoses of pressure ulcer to the heel, muscle disuse and atrophy. 1. Physical therapy was requested to evaluate and treat Patient #4. The initial evaluation for physical therapy revealed the frequency was to be twice a week for one week (week one), three times a week for three weeks (week two, three and four) and one time a week for one week	G 158			

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G 158	<p>Continued From page 17</p> <p>(week five). A telephone order on 4/29/09 revealed the physical therapy frequency was to be three times a week for four weeks (week one, two, three and four).</p> <p>Review of the clinical record revealed Patient #4 was only seen once on week one and three times a week from week two through week seven, with no evidence that the physician was informed or that additional orders had been received.</p> <p>2. Patient #4 was to receive wound care to her left heel three times a week. Review of clinical record revealed the wound care was to cleanse the left heel ulcer with normal saline, apply DuoDerm over the wound, and wrap with Kerlix, secure with Surgilast. This was to be done three times a week.</p> <p>The skilled nurse visit on 5/27/09, revealed the registered nurse did not perform the wound care as prescribed. The registered nurse documented the DuoDerm was intact and the dressing would be changed on Friday, 5/29/09. There was no evidence the physician was informed.</p> <p>Patient #6</p> <p>Patient #6 was admitted to the agency on 5/31/09, following an acute care hospitalization for a broken hip. She was prescribed oral Vancomycin upon her hospital discharge.</p> <p>1. A home visit and interview with Patient #6 on 6/16/09, revealed this medication had to be special ordered and was over 300 dollars. Patient #6 reported that she was not able to start the medication for over a week upon her return home. The patient also reported that she was not</p>			G 158			

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G 158	<p>Continued From page 18 taking it as prescribed (every six hours).</p> <p>2. An occupational therapy evaluation was requested as part of her admission orders, but there was no evidence this was completed. There was no evidence the physician was informed.</p> <p>3. An interview with the licensed practical nurse (LPN) on 6/16/09 revealed the LPN was not aware that Patient #6 was non compliant with her medications, and that the physician had not been informed. The physician also was not informed that Patient #6 had been seen three times instead of four during the first week of care, and four times the second week of care instead of three times.</p> <p>Patient #9</p> <p>Patient #9 was a current patient as of 6/15/09. He was admitted on 3/12/09, with a primary diagnosis of Vitamin B 12 deficiency. The physician prescribed weekly administration of vitamin B 12 injections for four weeks then the injections were scheduled monthly. He resided in an assisted living facility.</p> <p>Review of the clinical record revealed the patient received three of the four weekly injections (3/12/09, 3/20/09 and 3/27/09). There was no evidence that explained why the fourth weekly dose was not administered. There was no evidence the physician was informed.</p> <p>Patient #12</p> <p>Patient #12 was admitted to the agency on 12/6/08 and discharged on 2/3/09. His primary</p>	G 158			

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G 158	<p>Continued From page 19</p> <p>diagnosis was chronic obstructive pulmonary disease.</p> <p>1. Patient #12 was initially prescribed a licensed nurse three times a week and a nurse's aide once a week. Patient #12 was transferred to the hospital nine days after his admission on 12/15/08. A missed nurse's aide visit was documented on 12/16/08.</p> <p>An interview with the Administrator/Director of Professional Services (A/DOPS) on 6/17/09 revealed the nurse's aide was not informed of Patient #12's transfer to the hospital.</p> <p>2. Patient #12's initial referral from the VA (Veteran's Administration) contained a physician's order for occupational therapy. The typed plan of care for 12/6/08-2/3/09, included a hand written order by the physician specifically requesting occupational therapy evaluation and treatment. There was no evidence that occupational therapy was informed of these orders.</p> <p>An interview with the A/DOPS on 6/17/09, revealed occupational therapy were not instructed to evaluate this patient and that the physician had not been informed the order was not followed.</p> <p>3. Patient #12 was ordered for physical therapy twice a week for four weeks, starting week two through week five. Patient #12 was seen four times on week two and twice on 12/11/08.</p> <p>An interview with the A/DOPS on 6/17/09, revealed two visits were not charged, this was a mis-communication, but there was no evidence the physician was notified of the additional visits.</p>	G 158			

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G 158	<p>Continued From page 20</p> <p>Further review of the clinical notes revealed Patient #12 was admitted to the hospital 12/15/08 through 12/29/08. Home health was resumed on 12/30/09 (Tuesday). Patient #12 was not seen by physical therapy the remainder of the week, but was seen twice a week for the rest of the certification period.</p> <p>The clinical record did not contain any resumption of therapy orders, or to extend the period of therapy. There was no evidence the physician was contacted to inform him of the additional visits.</p> <p>Patient #1</p> <p>Patient #1 was admitted to the agency on Thursday, 5/28/09, with the primary diagnosis of pressure ulcer of the foot.</p> <p>A certified nursing assistant (CNA) was ordered three times a week. There was no specific start date indicated for the CNA. The clinical record revealed the CNA visit was not started until week two.</p> <p>An interview with the A/DOPS on 6/17/09, revealed the agency had to get approval for the CNA visits, but did not correct the plan of care to reflect the CNA would not start until the second week. There was no evidence the physician had been informed.</p> <p>Patient #10</p> <p>Patient #10 had a start of care (SOC) date of 6/7/09. Diagnosis included spinal stenosis with aftercare ordered following surgery. She was</p>	G 158			

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G 158	Continued From page 21 also a type II diabetic. SOC orders included that occupational therapy was to assess and evaluate. There was no evidence that as of 6/17/09 the assessment and evaluation had been completed. On 6/18/09, the A/DOPS concurred that the occupational therapy assessment and evaluation had not be done nor had the physician been notified.	G 158			
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to notify the physician of significant changes for 4 of 12 patients (#2, #3, #10, #11). Findings include: Patient #2 Patient #2 had a Start of Care (SOC) with the agency on 6/7/09. Diagnoses included a recent pneumonia and gastrointestinal bleed. She had a gastrostomy tube. Orders were to assess medication compliance, respiratory status, enteral nutrition, and to monitor for signs and symptoms of infection. Review of patient record revealed that Patient #2 has an initial visit with completion of the admission OASIS. After that, there was no	G 164			

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G 164	<p>Continued From page 22 evidence of ongoing care.</p> <p>In an interview, the Administrator/Director of Professional Services (A/DOPS) on 6/15/09, disclosed that after the initial visit, the patient was not sure that she was interested in the services of the agency. The agency had placed her in a "hold" status. The physician had not been notified of this situation.</p> <p>Patient #3</p> <p>Patient #3 was admitted to the agency with a SOC of 5/29/09. Diagnoses included chronic obstructive pulmonary disease and pressure ulcers. She had a gastrostomy tube.</p> <p>Orders were for physical therapy visits three times a week for four weeks. The week of 5/31/09, the patient had two physical therapy visits.</p> <p>In an interview, the A/DOPS on 6/16/09 acknowledged that the missed visit had not been made up on another day for the week.</p> <p>Patient #10</p> <p>Patient #10 had a SOC date of 6/7/09. Diagnosis included spinal stenosis with aftercare ordered following surgery. She was also a type II diabetic.</p> <p>SOC orders included that occupational therapy was to assess and evaluate. There was no evidence that as of 6/17/09 the assessment and evaluation had been completed.</p> <p>On 6/18/09, the A/DOPS concurred that the occupational therapy assessment and evaluation</p>	G 164			

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G 164	Continued From page 23 was not done nor was the physician notified. Patient #11 Patient #11 had a SOC date of 6/1/09 with diagnoses that included a fractured vertebrae, atrial fibrillation and urinary incontinence. The week of 6/7/09, the patient was to have had two skilled nursing visits for the week. Documentation disclosed that only one skilled nursing visit was made. The A/DOPS agreed on 6/17/09 that only one skilled nursing visit was made for the week and the physician was not notified of the missed visit.	G 164			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the agency failed to ensure that drugs and treatments were administered only as ordered by the physician in 6 of 12 patients (#3, #5, #9, #12, #1, #2). Findings include: Patient #3 Patient #3 was admitted to the agency on 5/29/09. Diagnoses included pressure ulcers of the elbow and buttocks, and chronic airway obstruction.	G 165			

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G 165	<p>Continued From page 24</p> <p>Review of the prescribed medications and Patient #3's compliance with the medication regime revealed multiple discrepancies between the hospital discharge orders, the medications Patient #3 was taking and the medications that the agency identified on admission as her current medications. There were duplications of medications, specifically Albuterol and Vitamin D. Many of the medications were changed on 6/1/09, but there was no evidence the agency documented the updated medications. There was no evidence the agency attempted to clarify the duplicated orders.</p> <p>Patient #5</p> <p>Patient #5 was admitted to the agency on 6/7/09, following open heart surgery.</p> <p>During a home visit, it was revealed that Patient #5 was taking medications other than what was identified by the admitting nurse or had been ordered after admission to the agency. The medication profile record had not been updated.</p> <p>Patient #9</p> <p>Patient #9 was admitted to the agency for administration of Vitamin B 12 injections. His start of care date was 3/13/09.</p> <p>Patient #9 was to receive injections weekly for four weeks and then the injections were to be administered monthly. Review of the clinical record revealed Patient #9 received three weekly injections before going to a monthly schedule. There was no evidence the physician was informed.</p>	G 165			

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G 165	<p>Continued From page 25</p> <p>Patient #12</p> <p>Patient #12 was admitted to the agency on 12/6/08, following an acute care hospitalization. His primary diagnosis was chronic airway obstruction.</p> <p>Review of the plan of care revealed Patient #12 was to have a home health aide, once a week for four weeks. Occupational therapy was to evaluate and treat. Physical therapy evaluated the patient on 12/9/08, and was to see the patient twice a week.</p> <p>The home health aide did not start until the second week, occupational therapy never evaluated the patient and physical therapy saw the patient four times the week of 12/7/08 and twice on 12/11/08. The physician was not informed.</p> <p>Patient #1</p> <p>Patient #1 was admitted to the agency on 5/28/09. His admission medication profile indicated he was supposed to be on a sliding scale insulin dosing for his fingerstick blood sugars. There was no documentation of the specific sliding scale orders.</p> <p>An interview with the registered nurse, Employee #2, on 6/17/09, revealed Patient #1 did not initially have any sliding scale insulin orders, but resumed taking the sliding scale insulin. There was no evidence the physician was contacted to confirm the current sliding scale insulin orders were correct. There was no indication the medication profile had been revised to include the sliding scale insulin coverage ranges.</p>	G 165			

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G 165	Continued From page 26			G 165			
G 170	<p>Cross refer to G 164</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the skilled nurse provided care in accordance with the plan of care for 5 of 12 patients (#1, #6, #5, #8, #7).</p> <p>Findings include:</p> <p>A stage three pressure ulcer was defined as a full thickness tissue loss, to include subcutaneous tissue.</p> <p>Patient #1</p> <p>Patient #1 was admitted on 5/28/09. His admission assessment data indicated he had a stage three pressure wound on his coccyx that was 10.0 centimeters (cm), by 6.4 cm, by 0.2 cm. Patient #1 had five other wounds identified. All wounds were to be cleaned with normal saline, solosite gel applied, and covered with sterile dry dressing and wrapped with Kerlix daily. The next wound assessment was done on 6/9/09. There was no mention of the wound on the coccyx. There was no order to discontinue the wound care to the coccyx. There was no evidence the physician was informed.</p> <p>Patient #6</p> <p>Patient #6 was admitted to the agency on</p>			G 170			

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NAME OF PROVIDER OR SUPPLIER HARMONY HOME HEALTH, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 820 RANCHO LN #20 LAS VEGAS, NV 89106		
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G 170	<p>Continued From page 27</p> <p>5/31/09, following a hip replacement. The agency was to provide wound care to the hip and inner right calf. At the time of the admission the calf wound was 3 cm, by 2 cm, by 0.5 cm.</p> <p>A home health visit was conducted with the licensed practical nurse (LPN) on 6/16/09. It was confirmed by the LPN performing the visit, that wounds were to be measured weekly, usually at the first visit of the week. Patient #6 had not been seen on 6/15/09.</p> <p>It was observed the LPN did not measure the right calf wound, although she acknowledged to the patient that the LPN was seeing the patient all this week instead of the registered nurse.</p> <p>Patient #5</p> <p>Patient #5 had a start of care (SOC) date of 6/7/09 with diagnoses that included aortic valve disorder, hypertension and diabetes. She was to receive aftercare for an aortic valve replacement.</p> <p>Review of the SOC orders revealed that no orders were given for the chest wound except to keep binder tight and in place.</p> <p>Documentation in the skilled nursing progress notes for 6/13/09 showed that the incision was cleaned with normal saline and patted dry and the binder was replaced.</p> <p>The Administrator/Director of Professional Services (A/DOPS) concurred that the wound care had been provided without the physician's order.</p>	G 170			

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G 170	<p>Continued From page 28</p> <p>Patient #8</p> <p>Patient #8 started as patient with the agency on 6/6/09. She had a diagnosis of hydradenitis resulting in the opening and drainage of numerous (5) wounds in the right groin and genital area. All the wounds were to be cleansed with normal saline and patted dry. The larger wounds were to be packed with moistened sterile gauze, the smaller ones with idoform gauze (moistened) and then all wounds were to be covered with ABD (thick dressing) and secured with tape or held in place with undergarments. Wound care was to be completed 5-6 times per week for two weeks.</p> <p>Wound measurements were taken on 6/6/09 at the Start of Service. There was no documentation of any additional wound measurements being done in coordination with the wound care up to time of the chart review (6/16/09).</p> <p>In an interview, the A/DOPS on 6/16/09 disclosed that agency policy was for wound measurements to be done weekly, preferably at the start of the week.</p> <p>Patient #7</p> <p>Patient #7 had a start of care date of 4/29/09 with diagnoses of paraplegia, and a pressure ulcer of the ankle. He also had a cystotomy. Measurements of the wound were taken at the start of care on 4/29/09. Review of the patient record showed documentation of additional wound measurements done on 5/6/09, 5/27/09, and 6/5/09.</p>	G 170			

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G 170	Continued From page 29 In an interview, the A/DOPS on 6/16/09 disclosed that agency policy was for wound measurements to be done weekly, preferably at the start of the week.	G 170			
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on interview, observation, and record review, the agency failed to ensure that the registered nurse case managers regularly re-evaluated 1 of 12 patients' nursing needs provided by licensed practical nurses, home health aides and document the care in the clinical record (#1). Findings include: Patient #1 A home health visit was conducted at the home of Patient #1, with Employee #2, the registered nurse case manager. The clinical record lacked documented evidence of supervisory visits for the aide. During the home visit, Employee #2 asked Patient #1 how the aide was treating him, but the nurse did not ask specific questions such as: the frequency of the aide's visits, the tasks performed, or if there was anything else needed to be or not to be done. The nurse did not evaluate if the aide was performing the tasks identified in the aide's plan of care.	G 172			

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G 172	<p>Continued From page 30</p> <p>An interview with the registered nurse, Employee #2, on 6/17/09, revealed the nurse did not perform supervisory visits for the licensed practical nurses and home health aides who provided care for Employee #2's patients. Employee #2 acknowledged she could not arrange her time to perform a visual supervisory visit with the home health aide to evaluate care. Employee #2 was not aware a supervisory visit was required every 14 days or less, but the aide did not need to be present.</p> <p>Employee #2 also confirmed she had several patients that were being seen by a licensed practical nurse, but could not confirm the care provided had followed the plan of care.</p> <p>An interview with the Administrator/Director of Professional Services (A/DOPS) on 6/17/09, revealed that there was no record of an evaluation by a registered nurse regarding the compliance of the plan of care by the licensed practical nurses except for the month of June, 2009. These evaluations were not identified as to which licensed practical nurse was evaluated. The A/DOPS also confirmed that when she performed an evaluation of a home health aide or licensed practical nurse, she did not evaluate compliance with the specific plan of care. The A/DOPS added she usually asked the patient how the staff member did and acknowledged it was probably the same with her nurses.</p>	G 172			
G 320	<p>484.20 REPORTING OASIS INFORMATION</p> <p>HHAs must electronically report all OASIS data collected in accordance with §484.55</p> <p>This CONDITION is not met as evidenced by: The agency failed: to encode and be capable of</p>	G 320			

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G 320	Continued From page 31 transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set (G321); to encode OASIS data must accurately reflect the patient's status at the time of assessment (G322); to ensure the home health agency (HHA) electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency at least monthly (G323); to ensure the HHA electronically transmit, accurate, completed, encoded and locked OASIS data for each patient to the State agency at least monthly for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirement of this paragraph (d) of this section (G324); to transmit data using electronic communications software that provided a direct telephone connection from the HHA to the State agency (G326); the HHA must encode and transmit data using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specification, and data dictionary, and that included OASIS data set (G327).	G 320			
G 321	484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set. This STANDARD is not met as evidenced by: Based on interview and review of OASIS information from the State system, the agency failed to transmit OASIS data for each patient within seven days of completing the OASIS data set. Findings include:	G 321			

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G 321	Continued From page 32 During the off site preparation, review of the OASIS State system revealed that no OASIS data had ever been received from this agency. In an interview with the Administrator on 6/15/09, she disclosed the following: The agency had been purchased from another company based in Utah in March 2008. Part of the purchase agreement was that the selling agency would continue to transmit the patient data into the OASIS State system. The Administrator further stated that she input the OASIS evaluations into a computer system (within the required timeframe) that relayed the data to the agency in Utah. That agency, in turn, was to transmit the data into the State system. She was not aware transmissions were not accomplished. She acknowledged that she had not received any validations that transmissions had been sent.	G 321			
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on interview and review of data in the State OASIS system, the agency failed to provide OASIS data that accurately reflected the patient's status at the time of assessment. Findings include: During the off site preparation, review of the OASIS State system revealed that no OASIS data had ever been received from this agency.	G 322			

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G 322	Continued From page 33 In an interview with the Administrator on 6/15/09, she disclosed the following: The agency had been purchased from another company based in Utah in March 2008. Part of the purchase agreement was that the selling agency would continue to transmit the patient data into the OASIS State system. The Administrator further stated that she input the OASIS evaluations into a computer system (within the required timeframe) that relayed the data to the agency in Utah. That agency, in turn, was to transmit the data into the State system. She was not aware transmissions were not accomplished. She acknowledged that she had not received any validations that transmissions had been sent.	G 322			
G 323	484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly. This STANDARD is not met as evidenced by: Based on staff interview and the review of data in the State OASIS system, the agency failed to electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency on an at least monthly basis. Findings include: During the off site preparation, review of the OASIS State system revealed that no OASIS data had ever been received from this agency. In an interview with the Administrator on 6/15/09, she disclosed the following:	G 323			

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G 323	Continued From page 34 The agency had been purchased from another company based in Utah in March 2008. Part of the purchase agreement was that the selling agency would continue to transmit the patient data into the OASIS State system. The Administrator further stated that she input the OASIS evaluations into a computer system (within the required timeframe) that relayed the data to the agency in Utah. That agency, in turn, was to transmit the data into the State system. She was not aware transmissions were not accomplished. She acknowledged that she had not received any validations that transmissions had been sent.	G 323			
G 324	484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on interview and the review of data in the State OASIS system, the agency failed to transmit all assessments completed in the previous month in an acceptable format. Findings include: During the off site preparation, review of the OASIS State system revealed that no OASIS data had ever been received from this agency. In an interview with the Administrator on 6/15/09, she disclosed the following: The agency had been purchased from another company based in Utah in March 2008. Part of	G 324			

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G 324	Continued From page 35 the purchase agreement was that the selling agency would continue to transmit the patient data into the OASIS State system. The Administrator further stated that she input the OASIS evaluations into a computer system (within the required timeframe) that relayed the data to the agency in Utah. That agency, in turn, was to transmit the data into the State system. She was not aware transmissions were not accomplished. She acknowledged that she had not received any validations that transmissions had been sent.	G 324			
G 326	484.20(c)(4) TRANSMITTAL OF OASIS DATA The HHA must transmit data using electronic communications software that provides a direct telephone connection from the HHA to the State agency or CMS OASIS contractor. This STANDARD is not met as evidenced by: Based on interview and the review of the data in the State OASIS system, the agency failed to transmit data using the electronic communications software that provided a direct telephone connection from the home health agency to the State agency. Findings include: During the off site preparation, review of the OASIS State system revealed that no OASIS data had ever been received from this agency. In an interview with the Administrator on 6/15/09, she disclosed the following: The agency had been purchased from another company based in Utah in March 2008. Part of the purchase agreement was that the selling	G 326			

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G 326	Continued From page 36 agency would continue to transmit the patient data into the OASIS State system. The Administrator further stated that she input the OASIS evaluations into a computer system (within the required timeframe) that relayed the data to the agency in Utah. That agency, in turn, was to transmit the data into the State system. She was not aware transmissions were not accomplished. She acknowledged that she had not received any validations that transmissions had been sent.	G 326			
G 327	484.20(d) DATA FORMAT The HHA must encode and transmit data using the software available from CMS or software that Conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set. This STANDARD is not met as evidenced by: Based on interview and review of the data in the State OASIS system, the agency failed to encode and transmit data using software that met the specifications of the CMS program. Findings include: During the off site preparation, review of the OASIS State system revealed that no OASIS data had ever been received from this agency. In an interview with the Administrator on 6/15/09, she disclosed the following: The agency had been purchased from another company based in Utah in March 2008. Part of the purchase agreement was that the selling agency would continue to transmit the patient data into the OASIS State system. The	G 327			

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G 327	Continued From page 37 Administrator further stated that she input the OASIS evaluations into a computer system (within the required timeframe) that relayed the data to the agency in Utah. That agency, in turn, was to transmit the data into the State system. She was not aware transmissions were not accomplished. She acknowledged that she had not received any validations that transmissions had been sent.	G 327			
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on home visit medication reviews, interview, and record review, the agency failed to ensure that the comprehensive assessment included a review of all medications the patients were currently taking for 4 of 5 patients with home visits (#6, #1, #5, #3). Findings include: Patient #6 Patient #6 was admitted to the agency following an acute care hospitalization for a fractured hip and surgical repair. She had been a patient of the agency since 5/31/09. Review of the clinical record revealed that orders from the hospital included a copy of the prescriptions that Patient #6 was sent home with	G 337			

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G 337	<p>Continued From page 38</p> <p>on 5/28/09. The prescriptions included the following:</p> <ul style="list-style-type: none"> - Albuterol 1 (as directed./nebulizer) every eight hours - Atrovent 1 (as directed/nebulizer) every eight hours - Prilosec 20 milligrams (mg) orally twice a day - Lactinex 1 orally three times a day - Percocet 5/325, one tablet orally every six hours for pain - Atenolol 50 mg orally daily - Colace 100 mg orally twice a day - FeSO4 (iron) 325 mg orally three times a day - Multivitamin one orally, daily - ZnSO4 (zinc) 220 mg orally, daily - Vitamin C 250 mg, orally twice a day - Vancomycin 125 mg orally, every six hours for 14 days. This antibiotic was prescribed for treatment of an intestinal infection known as C. diff. (56 pills had been dispensed). <p>Patient #6 was interviewed during a home visit on 6/16/09. Review of the medications she was currently taking and her understanding of these medications were assessed during the interview.</p> <p>Patient #6 still had 38 pills of the 56 Vancomycin that were dispensed, left. Patient #6 stated she "was only taking them three times a day, because she didn't want to get up at midnight to take the fourth pill." Patient #6 could not explain why she still had so many left, except it took her about a week to get the Vancomycin as it had to be special ordered and was more than \$300. 00 for the prescription.</p> <p>There was no Prilosec, Albuterol, Atrovent, Lactinex, Colace, Zinc or Vit. C or nebulizer located in the home.</p>	G 337			

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G 337	<p>Continued From page 39</p> <p>The agency failed to ensure that the plan of care accurately reflected the current medications of the patient.</p> <p>Medications on the plan of care that Patient #6 was taking without any discharge orders from the hospital to resume were:</p> <ul style="list-style-type: none"> - Furosemide 20 mg orally daily - Simvastatin 40 mg orally daily - Aspirin 81 mg orally daily <p>An observation during the home visit revealed the licensed practical nurse did not ask Patient #6 about her medication compliance. An interview with the licensed practical nurse at 2:00 PM on 6/16/09, revealed she was not aware that Patient #6 had not completed her Vancomycin therapy.</p> <p>There was no documentation the physician had been informed of the discrepancies of Patient #6's medication regime.</p> <p>Patient # 1</p> <p>Patient # 1 was admitted to the agency on 5/28/09 with diagnoses that included diabetes, foot ulcer and end stage renal disease. He also had a below knee amputation of the left leg.</p> <p>Patient #1 was interviewed during a home visit on 6/17/09. Review of his medications that he was currently taking and his understanding of these medications were assessed during this interview.</p> <p>Patient #1 was compliant with his oral medications: Imdur 60 mg daily; Allopurinol 100 mg daily; Omeprazole 40 mg daily, Norvasc 10</p>	G 337			

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PRINTED: 08/04/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2009
NAME OF PROVIDER OR SUPPLIER HARMONY HOME HEALTH, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 820 RANCHO LN #20 LAS VEGAS, NV 89106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	<p>Continued From page 40</p> <p>mg daily, Lipitor 80 mg daily and Paracelectrol 1 mg daily. Patient #1's med review did not include the sliding scale regular insulin, he was taking: 150-200, 5 units; 201-250, 8 units, 251-300, 10-12 units and greater than 300 he was to call physician.</p> <p>Patient #1's med review in the clinical record was not consistent with these medications: FeSO4 325 mg was listed as taking once a day, but the label indicated it was to be taken twice a day. Patient #1 stated he no longer took it. Nor was he taking the Vitamin C 500 mg daily. The clinical record indicated Patient #1 was to take enteric coated Aspirin 81 mg daily, but Patient #1 was taking non enteric coated Aspirin, 325 mg daily. Patient #1 was ordered Hydralazine 25 mg daily but he was taking it three times a day. Metoprolol was listed as 50 mg daily, but Patient #1 was taking it twice a day. Neurontin was listed as 100 mg daily, but Patient #1 was taking 300 mg three times a day.</p> <p>The medication review also indicated Patient #1 was to take Levothyroxine 100 mg daily, instead of the ordered dose of 100 mcg (micrograms) daily. There are 1000 mcg in a milligram.</p> <p>An interview with the primary registered nurse (Employee #2) on 6/17/09, revealed she admitted Patient #1 to the agency. The nurse acknowledged that she did not clarify what the sliding scale insulin dose should have been and used the wrong abbreviation for the Levothyroxine dose.</p> <p>An interview with the Administrator/Director of Professional Services (A/DOPS) on 6/17/09, confirmed she proofed the plan of care and did</p>	G 337			

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G 337	<p>Continued From page 41</p> <p>not question the wrong abbreviation. Both confirmed the primary physician had not been informed of Patient #1's current medication compliance variations.</p> <p>Patient #5</p> <p>Patient #5 was admitted to the agency on 6/7/09, following open heart surgery. A home visit and interview on 6/16/09, revealed discrepancies between the medication review the agency conducted on admission and the medications Patient #5 was taking, since admission.</p> <p>The medication review indicated Patient #5 was to take Endocet (Percocet) every four hours, but the medication label indicated this medication was only to be taken every four hours as needed. Oxygen was listed to be two to five (2-5) liters/minute, but the order was for 2.5 liters/minute. patient #5 was also taking Aspirin 81 mg, one every day, Tylenol 500 mg as needed for pain, and Ex-lax for constipation, but these medications had not been added to her medication profile.</p> <p>On 6/7/09, Patient #5 was ordered Lasix 20 mg every day for three to five days until edema was better. Twenty pills were dispensed. On 6/16/09, Patient #5 acknowledged she was still taking the Lasix because the swelling was not better. There was no documentation the agency was aware of this medication or the need to monitor edema. There was no documentation the physician was informed of the ongoing need for the Lasix.</p> <p>The medication profile also indicated Patient #5 was to take orally Nystatin Powder, which was a medicated powder that was to be applied to the rash under her breasts. An interview with the</p>	G 337			

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G 337	<p>Continued From page 42</p> <p>Administrator/ Director of Patient Services on 6/17/09, confirmed she proofed all the plans of care and med profiles, but did not identify the Nystatin powder had an incorrect route of administration.</p> <p>Patient #3</p> <p>Patient #3 was admitted to the agency following an acute care hospitalization for chronic airway obstruction. A home visit and interview was conducted on 6/17/09. Patient #3 explained that she required narcotic pain control to manage her arthritis pain. She was confined to a motorized scooter to ambulate. Patient #3 explained this most recent hospitalization was due to her stopping breathing, requiring mechanical ventilation and tracheostomy.</p> <p>The licensed practical nurse present at this visit indicated that Patient #3's pain medications were decreased to improve Patient #3's awareness, and this visit revealed Patient #3 alertness improved enough to review medications and her compliance with her med regime.</p> <p>The initial medication review conducted by the agency revealed Patient #3 was taking 19 medications plus oxygen. One medication was a topical ointment.</p> <p>The medication profile also indicated Patient #3 was prescribed two inhalers to be taken every 6-8 hours. (Combivent and Albuterol) Both inhalers contained Albuterol. There was no evidence that the physician had been contacted regarding this duplication of medication.</p> <p>A list of medications from the primary physician</p>	G 337			

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G 337	<p>Continued From page 43</p> <p>indicated Patient #3 was only prescribed 14 medications, nor had the medication profile for the agency been updated for the past 19 days. although nursing was making visits 2-3 times a week. This list of medications also included only the combivent inhaler.</p> <p>Discrepancies with the medication profile and the current medications Patient #5 was taking were:</p> <ul style="list-style-type: none"> - Fentanyl had been decreased from 75 mcg (micrograms) to 25 mcg patch (topical) to change every 72 hours. - Morphine 15 mg every six hours had been decreased to every eight hours (since 6/1/09). - Inhalers: Albuterol 90/Ipratropium and Proventil were to be administered four times a day, but the med profile indicate these were to be every 6-8 hours. Patient #5 acknowledged she only took the Albuterol twice a day. - Omeprazole 20 mg was to be taken two capsules every day, 30 minutes before a meal. The med profile indicated Patient #5 was to take 20 mg twice a day, and Patient 5 indicated she took two capsules three times a day. - Calcium 500 mg/ Vit D 200 mg were to be taken three times a day, and Vit D 3, 1000 units was to be taken once a day <p>On 6/1/09, the following meds were prescribed: Diltiazem 240 mg daily, Venlafaxine HCL 75 mg two pills daily, Ascorbic acid 500 mg daily, Calcium 500 mg and Vitamin D 200 mg three times a day, and were present in the patient's home, but had not been added to the med profile.</p> <p>Medications that were on the agency's med profile but not listed or present in the home were Tramadol HCL 50 mg, two tabs every four-six</p>	G 337			

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G 337	Continued From page 44 hours, Baclofen 10 mg every eight hours, Clonazepam 0.5 mg every 12 hours, Estrogen Conjugated 0.9 mg daily, Cymbalta 60 mg every night.	G 337			